



Health Care Planning and Accountability Advisory Council

Monday, November 5, 2012 2:30 pm

Department of Administration Conference Room "A"

Providence, Rhode Island

Co-chairmen: Christopher Koller, Commissioner, Office of the Health Insurance Commissioner

Attendees: Alyn Adrain, MD; Peter Andruszkiewicz; Timothy Babineau, MD; Jodi Bourque, Esq.; Al Charbonneau; Beth Cotter; Michael Fine, MD; Patricia Flanagan, MD; Marie Ganim, Ph.D.; Robert Hartman; Jane Hayward; Gloria Hincapie; Dennis Keefe; Eve Keenan, Ed.D, RN; Dale Klaztner, Ph.D.; Edward Quinlan; Mark Reynolds; and Fox Wetle, Ph.D.

Absentees: Kenneth Belcher; Douglas Bennett; Nicki Cicogna; Stephen Farrell; Herbert Gray; George Nee; Donna Policastro, RNP; Sandra Powell; and Louis Rice, MD.

Staff in attendance: Melinda Thomas, Senior Policy Advisor, Executive Office of Health & Human Services; Michael Dexter, Chief, Office of Health Systems Development, Department of Health; Kim Paull, Director of Analytics, Office of the Health Insurance Commissioner; Elizabeth Shelov, Chief, Family Health Systems, Executive Office of Health & Human Services.

Introduction

The Council meeting was convened at 2:30 pm by Christopher Koller, Health Insurance Commissioner. Commissioner Koller explained that Secretary Costantino had pressing personal business and would not be joining the group today.

The Commissioner reviewed the agenda. The May 2012 meeting minutes had been previously ratified by the Council. The meeting minutes from the September 20, 2012 meeting were reviewed and approved by the Council without amendments.

The Commissioner indicated that the bulk of this meeting will be a presentation by The Lewin Group of Washington, DC. The Commissioner invited public comment about this presentation at the end of the meeting.

A detailed work plan is included in Council members' packets. The Commissioner briefly reviewed the group's legislative charge and the work plan. He indicated that additional meetings may need to be scheduled in January and February 2013 to meet the aggressive time line. By February, a draft report to the Legislature should be completed. It is an aggressive work plan, but we are on track.

The Commissioner indicated that he was not going to address item #3 on the agenda (HCA and CoN sub-group reports). These ad-hoc committees will review the issues and report back to the full Council with recommendations. The meeting notes from the first ad-hoc group meetings will be circulated. To move this work forward, we need to let the subcommittees do their work and bring it back to the full group.

The next dates for the subcommittees are as follows: CON group meets [Monday, November 26, 2012 at 10:00 am in Conference Room "C" at the Department of Administration](#) in Providence. The HCA group is scheduled to meet on [Thursday, November 29, 2012 at 10:00 am in Conference Room "B" at the Department of Administration](#) in Providence.

The Lewin Group Presentation

The Commissioner introduced The Lewin Group staff to present an assessment of the needs of the state with a targeted analysis focused upon the demand for inpatient hospital services. This is not a final report. The focus is on demand/supply of hospital services. The Lewin Group is focused upon the future and how to model it. The Commissioner introduced Mr. Terry West, Managing Consultant at The Lewin Group, and Randall "Randy" Haight, Senior Director at The Lewin Group.

Mr. West began his comments by stating that this PowerPoint represents an interim report. As a beginning, we need a good understanding of issues related to hospital supply, demand, in-migration, and out-migration patterns. Today, Lewin will focus on "macro" issues, with the goal of informing a statewide health planning process.

See first slide: The primary goals of this project are to inform the state's planning decisions regarding future hospital inpatient capacity as determined by projected population need, developments in care delivery, and the impact of the Affordable Care Act (ACA).

Project framing questions include: What are the ideal number, location, and types of hospital beds that yield the best outcomes at the lowest cost? What is the cost of excess capacity?

A benchmarking analysis with neighboring New England states will be presented today. What are other states doing to manage inpatient bed capacity now? Features that key bed models have in common will be presented today. In January, Lewin will attempt to predict future inpatient bed need statewide. Analytic methods have included both quantitative and qualitative data sources. Discussions with expert witnesses will also be conducted.

Slide #4: Key analytic tasks: 1. Establish a baseline to look at a bed need model. 2. Benchmark demographics, quality, cost-efficiency benchmarks and 3. Present features of a bed need model.

Rhode Island's population has remained stable over last five (5) years. More so than the rest of New England, Rhode Island has an aging population. But, the gap is narrowing somewhat. The fact that Rhode Island is aging will impact demand. This will be taken into account when developing the bed need model. When inpatient days/1,000 population are adjusted for age and sex, Rhode Island falls below the U.S. average. Connecticut data were not available for slide #12. (Note that an error appears on slide #10: "NY" should be "NH").

Hospital utilization (inpatient days/1,000 population) is declining more rapidly than New England and the U.S. This drop-off happened quickly.

How were observation days handled? Observation days were not included, unless a patient was admitted. This is true for all New England and U.S. data. Any missing data sources are reflected in the footnotes.

On *slide #14* case mix performance is not remarkable. Rhode Island falls below Massachusetts for inpatient length of stay (adjusted for case mix) in 2010. The trend reflected in this slide has been persistent for the last 20 years.

Migration of care (*slide #15*): In the chart, there is tremendous migration out of Vermont and New Hampshire to other states. In Rhode Island, the trend is just the opposite. This is a very good number for Rhode Island and if it continues, the bed need model may not have to consider migration as is the case in New Hampshire and Vermont. This is a metric based upon discharges. Dr. Wetle questioned "What makes a good number?"

Slide #16: After adjusting for age, sex, and patient migration, Rhode Island utilization rates are similar to selected New England states and the U.S. Migration patterns do not affect Rhode Island significantly.

Slide #17 describes utilization by diagnostic categories: Rhode Island utilization is below U.S. averages for most of the diagnostic categories, with the exception of newborn services, digestive system diseases, mental health and alcohol/drug use diagnostic categories. When these diagnostic codes are cross-referenced with migration trends, it is clear that Women & Infants Hospital has a significant in-migration pattern. This slide is a "catch all" for the health status of the population. A host of diagnoses are included in each category. It was not possible to separate the diagnoses into "medical/surgical" categories.

Summary of Early Findings: On the utilization/demand side, there has been a slow decline in Rhode Island's population, but the elderly cohort continues to grow. ~~Inpatient use rates~~ Rates of admissions are falling, declining a bit faster here than in New England generally and in the U.S. Rhode Island lengths of stay are similar to benchmark areas.

Slide #19 On the supply side: staffed hospital bed capacity has increased slightly in Rhode Island, while decreasing nationally. Not much change has been seen here since 2006. There has been a slight decline throughout the U.S. on this measure.

On *slide #20*, staffed hospital beds/1,000 population, Rhode Island is in the middle of the pack. There is nothing terribly noteworthy about this slide.

Slide #21: Occupancy fell to 67% in 2010 and Rhode Island is now on par with its New England neighbors. Rhode Island inpatient occupancy rates are still above the U.S. average. The number of beds is going up slightly here, while in other areas, this measure is declining slightly. Occupancy rates reflect the point where supply and demand converge. (Example: the hospital has the capacity to serve 100 patients, but only 75 were in the hospital). These data reflect *staffed beds*. Declining occupancy rates are a function of increasing supply and decreasing demand, a condition referred to as a "mini-storm."

Mr. Keefe: Observation days are a factor in this measure. Medicare is the fastest growing piece of the Rhode Island market. Use rates should reflect observation days. Factoring in observation days will not change things directionally, but it would affect this specific measure.

Dr. Keenan: It takes the same resources to care for observation patients as it does admitted patients.

Slide #22 reflects the fact that Rhode Island's inpatient occupancy rates are above the national average for each bed type, primarily across medical/surgical beds and ICU services.

Financial health of Rhode Island's hospitals (**slide #23**): This is a 5-year average (2006-2010). The operating margins in 2008 "caved-in" due to the recession during that year.

Dr. Fine: With relatively higher occupancy rates and the relative financial distress of hospitals here, you have to examine payer mix, robust revenue streams, cost structures, and capital plans. If occupancy rates are higher, hospitals should be doing better if the payer mix is sufficiently rich. If Medicare is not a rich payer in Rhode Island, then you are teetering on the brink of financial health.

Mr. Quinlan: What was the methodology for calculating other states' operating margins on slide #23?

Mr. West: Methodology is cited on the bottom of the slide. Every organization in the country uses this metric and it is consistently calculated. Revenue expansion is associated with performing patient care. This metric does not include hospital-related research expenses.

Mr. Keefe: This metric looks pretty accurate for Massachusetts. This is an average. Could slide #23 be broken down by teaching and non-teaching institutions?

Slide #24: The average cost/discharge looks a bit high compared to all. When this measure is adjusted for area wages and case mix, Rhode Island falls in the middle of the pack.

Dr. Wetle is surprised at how low the average cost is in Massachusetts. There are high wages and many unions in Massachusetts hospitals. This chart does not make sense to her.

Staffing FTEs per occupied bed (**slide #25**): This metric has grown more rapidly here, but Rhode Island is still below the U.S. and below several New England states. New Hampshire and Vermont are outliers. The number of FTEs has grown. The question is why?

Commissioner Koller: Are staffing levels the same?

Dr. Wetle: Could there be an impact due to the lack of a public hospital? Should we compare by governance structure?

Mr. West: Studies go both ways on this issue. Some would say public hospital costs are higher, but it depends upon the setting. They will review these data further.

Slide #26 reflects clinical quality composite quality measures developed by CMS. These are used in CMS' value-based purchasing program. There is not much to differentiate Rhode Island from the U.S. Most hospitals have made substantial improvements in these measures, in part because hospitals have been planning for these measures. If a hospital is a high performer on a measure, additional reimbursement may be gained. Some would argue that CMS is not taking all of the appropriate factors into these risk adjustment measures.

Slide #28 describes the average total cost per medical/surgical bed by hospital. This is a quick look at average costs/medical surgical beds for 2010. The finding is that there is variation in the average

cost per occupied bed. A number of variables factor into these numbers. This is something Lewin will continue to review.

Dr. Keenan: She had her CFO look at this slide. **Dr. Keenan** pointed out that if this metric is calculated with square footage, new facilities will be more expensive. This is what we see here. What value does this slide have?

Mr. West: This is just an informational slide. What does excess capacity cost? This slide was the first shot at addressing this question.

Commissioner Koller: The benchmarking reflects that we do not have as much excess capacity as the rest of the country. What are other places paying for excess capacity?

Mr. West: It is terribly naïve to think that by eliminating ten beds, a great deal of money will be saved.

Dr. Keenan: Hospitals may need to replace beds and this has to be factored in.

Slide #29 discusses the impact on Rhode Island of the Affordable Care Act. It is estimated that by 2016, Rhode Island will have 89,600 fewer uninsured. What does it mean? As people become insured, they will use health services. There is a “catch-up effect” of 3.3% across the health care system.

Slide #31 is a summary of state approaches for managing excess inpatient bed capacity. Such approaches include state certificate of need programs (CON).

Slide #32: CON has traditionally managed hospital beds. CON has many supporters and detractors. Twenty-eight (28) states regulate the number of acute care hospital beds. All of these programs are east of the Mississippi River. There is much variation across CON programs. A common CON metric is the occupancy rate target, where new beds are not added unless established targets have been met on a service-specific basis. Targets are lower now than they were in the 1970s.

Slide #34: This slide describes Rhode Island’s task of going beyond CON in order to find the right supply of hospital beds, given future demand. We have to consider a comprehensive planning approach based upon community need. In developing the bed need model, the “planning area” will have to be defined. For some services, Rhode Island (the entire state) should be considered as the planning area. Rhode Island does not use its five counties for such designations. There is no perfect model!

Dr. Flanagan has her children’s “health hat on” and is thinking about how, in a small state, it is important to have specialized services together in one place. Quality outcomes happen when services are offered together. How does the volume/quality relationship affect the Lewin model?

Dr. Fine: Is there any evidence about the relationship between location, number of beds, and population health outcomes?

Mr. West: This is a parallel research exercise. Outcomes are defined within the hospital arena, not within the population health arena. The time line for analyzing the relationship between population outcomes and interventions is a long one.

Slide #36: Bed need projections will take into account demographics, medical practice changes, emerging models of care delivery, and the impact of the ACA. A key discussion will be to define planning areas. What will this measure be? Census tracks? The entire state? This has not been finalized yet.

Lewin will be developing a baseline projection of bed need by applying current use rates to projected population changes. From there, it becomes an art as much as a science. Assumptions will have to be validated and baseline bed needs may have to be adjusted. How much need for inpatient beds is declining? These are tricky questions.

Impact of the ACA: Lewin thinks it has a good handle on the impact of the ACA. There are emerging models of care to consider, such as health homes.

Dr. Babineau: Where do the teaching beds factor into the model?

Mr. West: The future role of medical education is linked back into the model. There has to be some consideration of the role of medical teaching and research. It is expensive. "A teaching bed is not just a bed." The bed is not just a cost, but it adds value back into the model. We cannot treat all beds the same. Medical schools contribute to the economy.

Commissioner Koller: Given that 50% of hospital revenue comes from outpatient services, how is Lewin looking at the outpatient side?

Mr. West: Lewin takes into account how many inpatient beds are going to be required in the future. They are not looking at the outpatient side per se, only as a means of projecting inpatient demand.

Dr. Keenan: The inpatient side uses services. All outpatients also utilize some of the same services. We have to analyze the outpatient side.

Mr. West: While the primary focus is on the inpatient side, we have to look at the outflow between the inpatient and outpatient sides.

Dr. Klatzker: Prevention services also have to be factored into the model.

Mr. Charbonneau: Is Healthcare Cost and Utilization Project (HCUP) data or any other high performance data being reviewed?

Mr. Haught: Such data are available but have not been factored in yet.

Mr. Quinlan: Is it significant that a public acute care hospital is lacking in Rhode Island?

Mr. West: When you eliminate a public hospital, you see a large increase in costs in the marketplace. An assumption is that CON is important because it protects public hospitals, although there is no evidence of this whatsoever.

Mr. Quinlan: Will Lewin look at this issue? No public hospital in Rhode Island?

Mr. Haught: If we anticipate a decrease in the number of uninsured in Rhode Island due to the ACA, is there a need for a public hospital? Lewin could do this comparison.

Mr. West: Where to go from here? Today we benchmarked supply and demand of hospital beds in Rhode Island. We looked at other states' trends. What is next? Two critical steps: 1. project Rhode Island bed need into the future; and 2. speak to knowledgeable sources in the community. What other things need to be considered?

Mr. Reynolds: The occupancy rate in all Rhode Island hospitals is in the 60-70% range. It can vary by hospital size.

Commissioner Koller: The matching of supply with demand is the occupancy rate.

Note that these findings are preliminary. Lewin has tried to distill our thinking.

Consider the following three points:

1. Effect of migration on areas of seeming overcapacity;
2. Effect of observation days. What are these effects?
3. Understand costs: what is going on in Massachusetts? Is Massachusetts's number artificially low?

We are going to have a great deal of work to do by January 2013.

Mr. Andruszkiewicz: Is the data source Medicare-only? Are we looking at commercial migration patterns?

Mr. Haught: The only national comparison data are from Medicare.

Dr. Keenan: We should look at commercial payers. We should have benchmarks for these patients.

Mr. Haught: We will contact Blue Cross/Blue Shield of Rhode Island. Providers also may be contacted.

Dr. Wetle (and slide #28) would like a bit more detail about how case mix was controlled for; could it make a huge difference in case mix severity measures? (Slide #28 was not case-mix adjusted).

Dr. Flanagan: Medicaid pays for at least 50% of children's care. Should Medicaid data be included in the discussion?

Mr. Haught: It is included in the hospital discharge data set, which was analyzed.

The formal Lewin presentation concluded at 3:50 pm.

Wrap-up

Commissioner Koller: The Council appreciates all of the work that The Lewin Group did on our

behalf and for traveling to Rhode Island to make the presentation. Note that this is interim work. Many other issues need to be understood.

The Commissioner expressed concern about the work load of the Council. Is there a need to have additional sub-groups? More meetings? Is there a more efficient way to do the work? Staff will work with Lewin in order to respond to the comments received here today.

Dr. Keenan likes small work groups set up to enable Council members to attend whenever they are available.

Mr. Andruszkiewicz is concerned about the modeling going forward from where we are today. The model builds upon the status quo; but the system that we have in place today will change. Taking this as the baseline and simply going forward frightens him a bit.

Commissioner Koller: So what approach should be taken? Do you want to think about projections within a system consolidation?

Dr. Fine: We could use different conceptual approaches, as the Graham Center is doing for their primary care study.

Commissioner Koller: Could you develop different scenarios?

Attorney Bourque: It is November now. The January deadlines are coming quickly. Should there be more meetings scheduled? Open meetings legal requirements must be met, so alternatives such as on-line communications, are limited. *Attorney Bourque* also expressed concern about staff preparing the findings when the group should be deliberating them first.

Mr. Quinlan: Perhaps some consideration could be given to delivering an interim report to the General Assembly in March 2013. We need to “get it right, not just get it fast.”

Dr. Wetle requested any and all Council materials be distributed in advance of the meetings.

Commissioner Koller indicated that staff will consider talking to General Assembly staff about the delivery of an interim report in March 2013.

Public Comment

The only public comment was from Mr. Donald Williams, former Associate Director of Health (Health Services Regulation). Mr. Williams encouraged the group to consider what the final end product will look like. Will it be a plan with beds by service area? If the final product is not considered, the group will flail around. The planning process involves many abstract ideas. At some point, political realities will set in. The process calls for subjective decisions. And there will be much community opposition. Think about what will constitute successful work by the group. And remember that CON is not a useful tool for rationalizing bed need.

Next Meeting

The next meeting of the Health Care Planning and Accountability Advisory Council is scheduled for: [Monday, December 10, 2012 at 2:00 pm in the Rhode Island Department of Health Operations Center](#), Lower Level, 3 Capitol Hill, Providence, Rhode Island 02908.

With no further discussion, the meeting adjourned at 4:00 pm.

Notes prepared and respectfully submitted by:

A handwritten signature in black ink that reads "Elizabeth Shelov". The signature is written in a cursive, flowing style.

Elizabeth Shelov, MPH/MSSW

Chief, Family Health Systems

Executive Office of Health & Human Services

November 7, 2012